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with them the whole time.
Q Why is that?
A I want to know what they think.
Q Helps for continuity of care?
A Continuity of care and for my learning.
Q It appears from this note that Dr. Billman was concerned about tightening up Mr. Davis's blood pressure control?
A Correct.
Q He wanted to see it lowered?
A Correct. He gave some parameters of where he wanted to see it, as I read that.
Q So then on the 10th, it looks like labs are drawn again?
A Correct.
Q And can you tell who made that entry?
A Norma Tyler.
Q And on the 19th, it appears you did a review of his medications?
A Partial.
Q Why do you say that?
A We try to get all medications on the same schedule. And this one was -- these two medications had fallen out of the every 60- or 90-day parameters. And so I did a temporary to get them back on schedule with the

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others.
I think I read there were seven different medications he was on. And so, instead of renewing one medicine today, another one tomorrow, two more in two weeks, every 90 days, typically, is when we'll want to renew them. So I put the Metoprolol and Coumadin back to renewal on the same date as the others.
Q Do you know why you were doing that review on the 19th?
A Because those two had run out.
Q Is there any indication that you saw Mr. Davis on the 19th?
A No. Typically I wouldn't under this scenario. The nurse would bring me the med sheet, saying that these two medicines are due to expire in the next day or two; we need enough to go until the next renewal date.
Q Then you gave an order that the INR draw was to be done again in 30 days?
A 30 days.
Q And his blood pressure and weight were to be checked again --
A Every month.
Q Why wait a month to check his blood pressure, given Dr. Billman's recommendation 11 days before that?
A I don't remember what I had in mind at that

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stage.
Q There's a notation also to the left of your handwriting. It appears to say, "Noted," and something else.
A Signature and a date, an LPN again. I think it's the same as this other one I have not been able to read.
Q Same as the one on 5/5?
A Yeah, and 5/19/02.
Q If I'm reading this correctly, then, that's simply a notation that --
A They took the order. They continued the med sheet so he could continue getting his two medications.
Q And that an INR would be done in 30 days and blood pressure and weight checked --
A Uh-huh.
Q -- again in 30 days? All right.
The next entry, 5/30/02, seems to refer to a fax from the Haines clinic?
A Correct.
Q Do you know whose handwriting that is?
A Cora Benoit.
Q Do you know what the fax related to from Haines clinic?
A Off the top, no. I'm assuming that would have

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been his private physician.
Q On the next page, it appears most of the handwriting belongs to Mr. Hughes again?
A Okay. Yes. Well --
Q Actually, there's a lot of handwriting, but...
A -- and Cora Benoit.
Q Your handwriting appears next to the order for a repeat INR in 30 days --
A Right.
Q -- on 7/12/02?
A Correct.
Q And also down on 8/16/02, at the bottom?
A Correct.
Q Is your handwriting anywhere else?
A Not on that page.
Q Going back for a moment, if we can, to page four, the transfer note that was made by Ms. Hawkins indicating that PT and INR should be done in about two weeks --
A Uh-huh.
Q -- once Mr. Davis came to Palmer, you changed that to every 30 days, right?
A Well, eventually, yes.
Q Why?
A When somebody is stabilized on their Coumadin,

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our standard of care is every 30 days. If there's a problem and we alter the medications, you know, increase or decrease the amount of Coumadin, we can do that in a shorter time frame, every 10 to 14 days.

Q So is it fair to say that you concluded his Coumadin was stabilized?

A His INR.

Q His INR was stabilized?

A Yes.

Q And you would not have waited 30 days?

A Correct.

Q Is it fair --

A And then we have, like, Dr. Billman review that to see if he wanted to make any changes. And he didn't on the visit that he came in on.

Q Is there any indication, in Dr. Billman's note of 5/8, that he reviewed the lab work?

A He didn't write it down. From my experience working with him, he would do that.

Q But any comments, then, that he had about the lab work would not appear in here?

A He didn't write anything down.

Q Would Dr. Billman make notes anywhere other than the progress notes?

A No.

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Q Progress notes is the location where everybody involved in the inmates' care should be making notes, right?

A Correct. There's a separate section for dental and psychiatric.

Q Okay. In terms of the medical side, at least, this is where they should appear?

A Should be. Uh-huh.

Q If we look at the note from April 28th, on page five, that's Mr. Hughes's note?

A Correct.

Q And there's a report on the INR?

A Correct.

Q The INR at that point was 1.9 --

A Correct.

Q -- which was not considered a stabilized level, right?

A Wasn't therapeutic, correct.

Q Was outside the therapeutic range?

A Just a tad low.

Q What was the therapeutic range for somebody with an implanted defibrillator?

A 2 to 3.1, on Mr. Hughes's note. But it's not -- my understanding, the Coumadin is not because he had an implanted defibrillator. The Coumadin was because he had a prior MI, myocardial infarction.

Q Otherwise known as a heart attack?

A A heart attack, in lay terms.

Q Did the fact that he had an implanted defibrillator make any difference to the Coumadin?

A The dosage?

Q Yeah.

A Not to my knowledge.

Q Did the therapeutic level of Coumadin vary depending upon whether or not he had an implanted defibrillator?

A No. The implant doesn't change the lab value.

Q Does somebody with an implanted defibrillator need to have Coumadin?

A I don't believe just the fact that they have the implant in and of itself would be reason to be on Coumadin. But the reason they have the implant, prior MI or other, would be reason to put them on the Coumadin.

Q So it goes hand in hand, but there's not a causal connection, if you will?

A As I understand it.

Q Okay.

A Typically you see them together, but they're both treating the same condition but for different reasons.

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Q Do you know whether there's a different therapeutic range for Coumadin depending upon whether somebody has an implanted defibrillator or not?

A I guess I'm not understanding.

Q Well, when we're looking at a therapeutic range that Mr. Hale [sic] has here for --

A Hughes?

Q -- sorry, Hughes -- on the 28th for the INR of 1.9, you said that was a tad low.

A Well, 1.9. It should be at least 2. So I guess "yes" is the answer to your question.

Q Okay. So when somebody has an implanted defibrillator, is there a different therapeutic range than you would see if somebody doesn't have a implant?

A Again, they kind of go hand in hand. So, yeah -- it would be like -- there's a reference range on the lab slip if they have a mechanical valve or, you know, if they're being treated post MI, and that's what I'm looking at.

Q Okay. PT at 18.4, was that a therapeutic range?

A I'd have to look back at the thing. I believe that's just slightly low as well.

Q In any event, you would agree that Mr. Davis's condition was not stabilized enough for his PT/INR to run 30 days, at least as of April 28th?

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A That's why he wrote the order to do it again. And then my order was after that was done.

Q And that order was consistent with what Shirley Hawkins had written on the 22nd when he was transferred?

A Correct. Correct.

Q Is it fair for us to assume, then, that, when you wrote the order on May 19th to draw the INR in 30 days, that you concluded he had stabilized by that point in time?

A That would be my assumption.

Q Is it also fair for us to assume that you concluded, on May 19th, that his blood pressure had stabilized?

A No, not necessarily.

Q Why would you wait 30 days to recheck that, then, if his blood pressure --

A Because they were just starting to do some changes on him. He wasn't severe hypertensive.

Q Do you know how often Mr. Davis's blood pressure was checked after Dr. Billman's recommendation to tighten control on it?

Okay. And you're showing me a vital sign flow sheet.

A The order that I wrote was a minimal order. And the nurses again have a lot of discretion and they do a

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lot more than necessarily what the minimal order is. And this would have been made available to me on the 5/19 date, the vital signs flow sheet.

MR. MATTHEWS: Mark that as the next exhibit.

(Exhibit 5 marked.)

BY MR. MATTHEWS:

Q Exhibit 5, the vital sign flow sheet, is the same document you just pulled out of your working file, right?

A Correct.

Q And that's what you just showed me a moment ago?

A Correct.

Q And this tells us that, after Dr. Billman's order on the 8th of May, 2002 to tighten up control of his blood pressure, that it was reviewed again through June 11th, 2002, right?

A Right.

Q And after that there's no further monitoring?

A Not on this sheet. The nurses again would do that. I don't know if they started another sheet or if they felt it was in his parameters which he had written.

Q Is there any indication in the records, that you see, that Mr. Davis's blood pressure was checked again after June 11th, 2002?

A Not that I see.

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Q If Mr. Davis's blood pressure had been checked after June 11, 2002, would you agree with me that that should appear either in the health care progress note that we've had marked or in the vital sign flow sheet?

A It could be in the progress notes. It could be on the flow sheet. It could be on the medication dispensing form. And it could be on transfer sheet.

Q But it should be reported somewhere if it was done?

A You would hope somebody would write it down. It happens where they don't write it down.

Q From a medical standpoint, can you think of any good reason to take a blood pressure and not write it down?

A No. Do I see that happen routinely? Yes.

Q Why?

A I don't know. I always write down when I take them. Weights, blood pressures, all of that. I've seen -- in all the years I've been working, people do it and then don't document it.

Q Makes it difficult to have accurate information about a person's condition when people don't write it down, right?

A I would agree with that. How we take notes in medicine has changed significantly from when I first got

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into medicine in 1974 until today. It's completely changed. It used to be a record for myself on what I've done. It's now become a legal document, you know.

Not everybody has progressed with the times, especially some of the older physicians. You'll find they don't write everything that I would write.

Q You get no disagreement from me on that point.

A You've seen some of the old -- but it's changed. In my lifetime it's changed significantly, what a medical record was in the old days to what I see it as today.

Q So there's people writing down less information today?

A They shouldn't be.

Q I agree.

A But are there people out there that don't? Correct.

Q From your standpoint as the institutional health care officer for PCC, you would expect everybody reporting to you to write down vital signs if they took them, right?

A I counsel that on a routine and regular basis.

Q And despite your counseling, people don't always follow that order; do they?

A That's correct. They'll take a blood pressure and then they don't write it down. And normally that's when it's a completely normal value.

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Q Are there also occasions where people take blood pressure and it's not a normal value and it doesn't get written down?
A I've not caught them doing that; I've not seen that.
Q But then again, you can't tell when it isn't written down?
A Oh, if I'm not there and watching what's going going on.
Q Who has access to the medical chart?
A Medical providers and the nursing staff.
Q Do correctional officers have access to it?
A No. They -- we'll seal them up to go to another facility, but they are not to come in and read through the chart. It's a confidential document. The superintendent cannot do that. The dental, psychiatric, medical providers, and nursing staff are the only ones that have direct access to the medical file.
Q And they're the only ones that are supposed to be making notes in the medical file?
A Correct. Now, I can receive a memo from security about an inmate's involvement in whatever, and that may go in the medical file. But they're not coming in and writing in the medical file. Somebody gets in a fight or, you know, they're found doing drugs or alcohol

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or whatever else, and security will send a memo to let us know, that might go in the medical record.
Q Are there indications -- strike that.
Are there times when security may find a medical situation after medical staff has left for the day and then send you a note about it?
A Possibly. More often than not, they would call me.
Q And let you know?
A Yeah.
Q And should that appear in the medical file?
A If I received a phone call, yeah, I would put it in there.
Q What documentation would there be in the medical file if an inmate had a problem with dizziness after the medical staff had gone home and he was taken out of his cell to be checked?
A What documentation would be available? If it was a security officer, I would hope that they would either call me, or whoever's on duty, and/or send like a memo of what they found. And that would -- either I'd have the memo in the chart and/or, the next day when I come in, I would make the chart entry.
Q About your phone call?
A About the phone call.

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Q Do you ever remember receiving a phone call about Charlie Davis?
A No. The only time I would be called is when I was "on call."
Q Let me make sure I understand the "on call" then.
A The seven days I work, I'm on call those seven days. The next seven days, when Hughes is on call, he does that. If one of us is on vacation, a third party may be on call for that period of time.
Q So if it was your week to be working, you're the "on call" person?
A Normally speaking. There are instances where I don't pull call for specific reasons, and then it would be -- we have an "on call" system. There's always a backup. There's a statewide "on call." So if I'm someplace, like in this building, and my cell phone didn't ring here, the medical security staff could call the statewide "on call" person to get orders. There's always a backup.
Q As I understand it, you were the one that made the decision to change Mr. Davis's INR draw to every 30 days, right?
A At that stage, subject to change each time you look at the lab test.
Q You made that decision without examining him,

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true?
A My guess is I probably just reviewed the lab result.
Q Is there any indication in the chart notes that you examined Mr. Davis other than on May 2, 2002?
A No.
Q Is there any indication in the chart notes that a physician ever examined Mr. Davis?
A I have no idea, on the 10/28/02 entry, who that is. I don't know if that was -- I have no idea.
Q 10/28 is on the Lemon Creek notes, right?
A Correct.
Q While he was at Palmer, is there any indication that he was ever seen by a physician?
A Not that I see in these notes.
Q During that time period, from the end of April until the end of October 2002, did you have a physician coming through Palmer on a weekly basis?
A I would think so. That was the routine at those stages. Again, there were times when something would happen that maybe one week here or there somebody didn't show. But by and by, there should have been at least one physician a week, and with Dr. Billman coming in sometimes there, too.
Q How often was Dr. Billman actually coming

Exhibit 21
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through?
A I want to say at that time once or twice a quarter. He wasn't coming very often.
Q So is it possible that this entry by Dr. Billman was the only time he came through while Mr. Davis was there?
A It's possible.
(Exhibit 6 marked.)
BY MR. MATTHEWS:
Q Take a look at Exhibit 6, if you would.
A Okay.
Q Do you recognize those documents?
A Yes.
Q Is that a collection of the lab reports for Mr. Davis's PT and INR tests that were done while he was at Palmer?
A It appears so.
Q Are you aware of any other PT and INR test reports for the time period that he was at Palmer?
A No. Each one of these numbers should reflect --
(Off record.)
THE WITNESS: The number in the progress notes should reflect down here on the requisition number.
BY MR. MATTHEWS:
Q Okay. That's where that should appear, then?

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A Right.
Q And the requisition number appears down in the lower left-hand corner of each of these sheets?
A Correct.
Q At least on the ones that were done by DynaCare, that's true. Does that also appear to be the case on the Quest Diagnostics?
A It should be. I think that's the time we just changed our lab provider. They're contracted.
Q So I could just -- yeah, it looks like it's just cut off here where it says, "Requisition," up in the upper left, on the Quest sheet.
A Yeah. It's the same idea.
Q There's handwritten initials appearing on the first page of this exhibit.
A Roger Hughes, right.
Q That's Roger Hughes in the circle? Same thing on the second page?
A Yes.
Q And on the third page?
A Mine.
Q That's yours? Okay.
Fourth page, is that Roger Hughes again?
A Hughes.
Q Fifth page is yours?

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A Correct.
Q And sixth page?
A Another facility. I think that's Juneau.
Q And that's for the one on September 20 --
A -- 3rd. It was initialed on 23 September '02.
Q Okay. Would you agree with me, Mr. Hale, that, on each of the reported lab results, the PT test portion of the test was outside the reference range?
A Yeah.
Q Is it fair to conclude that, in ordering Mr. Davis to continue with PT and INR tests on a 30-day basis, that you essentially ignored the PT test?
A Again, like I stated earlier, the INR is more indicative of what it is that we're trying to treat. The PT is always going to be off with the Coumadin. There's no way to get it back into a normal range, that I'm aware of, and provide the therapeutic effect that you need from the INR. I'm not going to change the medication based on a PT.
Q Only based on the INR?
A Well, not only, but that's where the key to the treatment is, is in the INR. There are some folks that recommend only an INR be drawn now.
Q On the Quest report that appears on the -- appears to be the fourth page of the exhibit, it gives

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three different ranges for the INR -- reference ranges. Do you see that?
A Uh-huh.
Q One is for somebody who's not on anticoagulant therapy, meaning Coumadin, right?
A Right.
Q And then there's another range for routine therapy?
A Uh-huh.
Q And a third range for somebody who's got a mechanical prosthetic valve, right?
A Correct.
Q Is there a similar set of ranges for the PT test?
A Each lab will have its own reference ranges. And if they have that, they're required now, under what I believe is the CLIO (ph) rules, that they have to document that on these forms.
Q If we look at these lab reports together as a progression, it appears that, on the initial report of April 26, Mr. Davis's INR at least was on the low side, right?
A Right.
Q And the PT test was high, but just barely --
A Correct.

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Q -- right?
Then we go to the May 10th report, the PT test is higher again?
A Right, as his Coumadin was increased.
Q Okay. And the INR is higher --
A Within the therapeutic range.
Q -- and now within the therapeutic range. And that stays consistent to the June 24 report?
A Uh-huh.
Q And once we get to the July reports, the INR is higher again and so is the PT, right?
A Right.
Q And the INR is almost out of the therapeutic range?
A Right.
Q And the INR is significantly higher, right? Excuse me. The PT is significantly higher, right?
A Right.
Q The same thing is true again on the August 15th test, right?
A Right. Well, INR was the same. PT was just slightly elevated on that one.
Q Again, the INR almost out of the therapeutic range, right?
A Well, at the high end. Still in the range,

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but...
Q Did that progression cause you any concern for Mr. Davis at the time?
A Not that I remember. Again, at that time I would have the physician that came in reviewing along with it.
Q But we don't see any indication that a physician looked at this other than Dr. Billman?
A Yeah, they didn't necessarily make a note, but I would -- that was my standard of practice then, was to have them review.
Q Is there any indication that you can show me in the records we've looked at, either the vital sign sheets, the progress notes or the lab reports, that a physician other than Dr. Billman ever reviewed Charlie Davis's medical file?
A Not that they wrote down.
Q Do you have a specific memory of having discussed Charlie Davis with a physician?
A Other than my standard of care that I provide. I mean, I know what I do. I ask them to review -- PTs are something they review every time they can come in, if there's been one drawn. We now have a formalized way of documenting that that we didn't have in the past.
Q And what is that formalized way?

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A It actually goes into both the pharmacist and Dr. Luben. As an internal medicine doctor he's taken some hands-on approach to things like Coumadin management.
Q That were not present before he was there?
A Correct.
Q How is the documentation different?
A Well, I mean, there's a formalized process that they follow now, where the lab results are faxed to central office, to the pharmacist and to Dr. Luben. And if they have recommended changes, they send that to us in writing.
Q Okay. So in the old days, if I can call it that, the lab results would be sent simply straight to PCC?
A Correct. We have a printer that goes from the lab straight to my desk.
Q And so the lab results would be available for a physician coming through on a visit --
A Correct.
Q -- but they would not be sent directly to a physician --
A Unless there was a problem. A phone call might be made.
I encourage my physicians at every opportunity to make a note that they have reviewed whatever it is that

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I've presented to them, but unfortunately they don't always document that.
Q Was that something you were encouraging your physicians to do back in 2002?
A Always have.
(Exhibit 7 marked.)
BY MR. MATTHEWS:
Q Do you recognize Exhibit 7 at all?
A I recognize what it is.
Q You don't remember seeing the document?
A Not off the top, no.
Q What it is -- appears to be an order from Mr. Davis's private physician in Haines that he should have an INR test done twice monthly, right?
A It's a prescription.
Q When an inmate comes into PCC, how do you deal with the fact that they may have prescriptions from a private physician?
A I follow the policies and procedures of the department. This provider has not requested practice privileges in the Department of Corrections, so I can only take this under advisement. Whether it's for a drug, a lab test, surgery, whatever, we take it under advisement. Then either myself or one of the other providers have to write our own orders.

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Q So as a matter of formal policy, you can't follow this as an order --
A Correct.
Q -- but you can take it as a suggestion of a treating physician --
A Correct.
Q -- and consider it for what it's worth?
A Correct. It's the same with any prescription.
(Exhibit 8 marked.)
BY MR. MATTHEWS:
Q Do you recognize Exhibit 8?
A From the package I previously had, yes.
Q Did you write that memo?
A No.
Q Do you know who did?
A Nope.
Q Is there any way to know who did?
A No.
Q But you know you didn't?
A I do know that for a fact, because I always sign my memos that I do. I don't have a secretary; I type all my own. And you will see my initials and/or name on every memo. I can't think of any time I have not put it down.
Q So you know for certain that it wasn't you --
A Correct.

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Q -- but beyond that we can't tell?
A No idea.
Q Would it have been somebody on your medical staff?
A My guess would be one of the nurses.
Q Do you know why this memo was written?
A My guess is is that Mr. Davis said something to one of the nurses about him being wanded by security. And I'm guessing Mr. Davis provided the copies out of his book that the state wanded him, which is a routine thing. Sergeant Barnhart, who was a shift supervisor at that stage, would be required, every time an inmate moved from one place to another, would have to wand down as part of their screening process.
Q And somebody with an implanted defibrillator, wanding them down, not necessarily a good idea?
A Correct.
Q Yeah.
A And it explains it in the pamphlet.
Q Right. So the purpose of this memo appears to be fairly self-explanatory --
A Yes.
Q -- to alert the security staff that this guy has got a special condition and you can't do things because of his defibrillator?

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A That is part of the screening intake when they come in, the nurses. That's one of the things that they try to elicit from the new inmate coming in, that they have a special need. And they get transferred from place to place and sometimes they don't remember to tell us, the day they walk into the facility, that they have this type of special need. And so a few days after they're in, it's, oh, by the way.
Q Were you aware of this memo at the time Mr. Davis was there?
A Not specifically. I certainly wouldn't have had a problem with it. If it would have gone directly through me, I would have signed off on it, but it's not something that would require my signature on it. It's an appropriate thing to do -- for the nurses.
Q Correct me if I'm wrong, but it sounds like your hands-on involvement with Charlie Davis was pretty limited?
A Correct.
Q You had the one examination when he came in for leg pain?
A Correct.
Q But other than that --
A And his grievance.
Q But from a medical standpoint, to coin a phrase,

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you pushed some paper about Mr. Davis, but you weren't actually involved in the day-to-day care?
A Pretty much.
Q Mr. Hughes had more contact with him?
A Yes.
Q Would you and Mr. Hughes sit down and talk about specific inmate cases at any given time?
A Sometimes yes, sometimes no.
Q If there was a particular problem, you might discuss it?
A Possibly, yeah. If somebody has died or, you know, a catastrophic event or something, or if we want somebody to follow something special from week to week. We have -- we talked to each other at the end of our work weeks.
Q Kind of a shift change, if you will?
A Uh-huh.
Q Otherwise, the reason for having progress reports, progress notes, is to make sure that you can have continuity of care?
A Oh, yeah. That's a given. The Department of Corrections rotates people on a routine basis, and so we have to be able to contact -- you know, let the next facility know.
When I first started at PCC, the average stay

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was, I think, three and a half years on the medium side. And now it's like 30 days. So it's changed significantly.

Q Okay. So you've got people rotating in and out of there on a regular basis?

A And that's not special for PCC; that's department-wide.

Q Why so much movement?

A You'd have to ask the administration. It has to do with putting -- they're designated community custody, minimum, medium, maximum, closed, what have you, and they have to put people in beds that are available.

In the olden days, theoretically, when somebody went to jail, they went to maximum security, progressed to medium security, to minimum, to community. That was the theoretical model. And now we get people coming into jail that are community custody eligible from the get-go. It's all changed. And I don't know all the details of why they've done what they've done. We also send people to Arizona. You know, just a variety of places they go.

Q Does it make it more difficult for you to do your job when you're getting people rotating in and out?

A It's changed how I do my job. I don't know -- "difficult" is a relative term.

Q More challenging?

A It can be. When you have somebody three, five,

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ten years, it's a lot easier to do long-term maintenance than somebody we've had for six months. You know, you're just starting to get to know the person, then they're gone. Just a different way of working.

MR. MATTHEWS: Let's go off record for a minute.

(Off record.)

(Exhibits 9 and 10 marked.)

BY MR. MATTHEWS:

Q Mr. Hale, while we were off the record, we've now marked as Exhibits 9 and 10 to your deposition some documents relating to a prisoner grievance filed by Charlie Davis; is that right?

A Correct.

Q Starting with Exhibit 10 first, the first page of that exhibit appears to be Mr. Davis's grievance, right?

A Correct.

Q And then you were tasked, in your position as the institutional health care officer, with responding to that grievance?

A As well as investigating the grievance.

Q And then the second page of Exhibit 10, is that your investigation?

A Yes.

Q And it appears in the top portion of it,

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correct?

A Correct.

Q And your answer is, "The issue of manning/staffing cannot be addressed at this level. I spent about 20 minutes explaining how he can access medical (that is available at PCC);" is that right?

A Correct.

Q So that was the sum and substance of your investigation?

A Correct.

Q Mr. Hyden then reviewed your investigation, right --

A Right.

Q -- and concluded that your investigation didn't address the grievance?

A Correct. What he's asking for is something that I could not provide.

Q "What he," meaning Charlie Davis?

A Charlie Davis, correct.

Q And what was it that he was asking that you couldn't do?

A He wanted to have Palmer Correctional Center staffed 24 hours a day with nursing staff that he had access to.

Q And that wasn't something that you could help

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him with?

A Absolutely not.

Q Why not?

A Well, first off, inmates don't set up staffing levels. And second off, I don't establish staffing levels. That's done through the department.

Q Did Mr. Davis explain to you why he felt that 24-hour nursing care was needed at Palmer?

A In a roundabout way, yes. What he -- what I spent the majority of my time talking with him -- that's the first thing I did. What do you mean in this grievance. What is it -- let's get away from the legal terms and all the rest. What is it that you want that's not being met.

And what he had the biggest concern with is that he didn't know -- he claimed he didn't have any knowledge of how to contact me directly or PA Hughes or even one of the physicians that come in.

And that's why I went through -- I spent a long period of time on how he can access medical. If he feels he needs something specific, he has to put it in writing. If he catches one of the nurses out in the dining hall and talks to them, she's probably had 10 other people say something and the message may not get to me.

In the inmate handbook and in the orientation

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when screening in, it explained what it is they need to do to access medical, and he claimed that he didn't understand or didn't comprehend what it was that he was told at Lemon Creek and then when he came to PCC. So I spent 20 minutes explaining it to him.

So that part of his grievance I could address, but the staffing...

Q Did he explain to you why he thought 24-hour staffing was important for PCC?

A I believe he tried to, if i remember the conversation. I don't remember the exact words; it was some time ago. But I think, yeah, in essence he wanted it to be a nursing facility, a nursing home, and the Department of Corrections at PCC doesn't provide that.

Q Did he explain to you that he was concerned about the quality of care he was receiving?

A I don't know if he used those terms, but he was concerned that he didn't know how to contact me or the other providers if he had a specific problem.

Q Did he explain to you that he didn't feel that the care he was receiving was adequate?

A I believe so, but again, based on he didn't know how to ask for it.

Q And from your standpoint, it was his responsibility to ask, not PCC's responsibility to --

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A I can't be responsible for what it is that he thinks he needs to have. That's why we have the process of screening in, to have them tell me that something is overdue or is needed. It's his responsibility to let us know.

Because we have such an overturn of inmates, it's impossible to track every little thing each person wants. And just because I've ordered something at PCC doesn't mean, when he gets to Lemon Creek, that they necessarily have picked up that order.

Q So that's why you do the transfer screens?

A Correct. And that's why it's imperative that these guys write a COP-OUT -- if they're having a heart attack, they -- you know, they let the first person know who implements the EMS systems. That's another issue.

If they have routine care, they need to let us know, and he does that in a COP-OUT. And I explained that to him. You've got to send it to me in writing. You catch somebody out on the floor, if you complain to your house officer, the shift sergeant or one of the nurses verbally, they're not going to discuss it with you because it's a violation of confidentiality and it may not get back to me. And he seemed very pleased with my response from that end.

Q So basically your response to him was, put it in writing and it will get to me?

A And I explained how he does that.

Q Okay.

A And to not just talk to anybody out in population that -- you know, that works for the state. Unless it's an emergency.

Q And emergencies are dealt with differently, obviously?

A Correct. Correct.

Q After your meeting with Mr. Davis, what further involvement did you have with his grievance?

A I don't think I had any further. I fill in my section; it goes to the superintendent. He did his response to that. And then Mr. Davis had the opportunity to appeal that decision because I could not address what it is that he wanted on this. I don't have the authority at my level to say, yes, we need 24-hour nursing care at PCC.

Q Mr. Hyden, in his response to your investigation, suggested that Mr. Davis perhaps should be transferred to another facility?

A And as a superintendent he has that right.

Q Okay.

A I don't remember him talking to me about that or why he felt that way.

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Q Typically, how does the grievance work? Once you've done your investigation, the paperwork then goes to the superintendent to review?

A Right, and it's been called the facility administrator, used to be the grievance officer.

And they have specific things that they say; they agree with my findings or they disagree with my findings. And in this case, it was I didn't -- I couldn't address what it was that he was asking for.

Q Is there some process in there where you and the superintendent discuss the grievance?

A Not necessarily. Very rarely. If they had a question to me, they would ask. They'd call me up or, on our Monday morning meeting, would ask something along the lines. But chances are they'd just give me a phone call.

Q In a situation like this, where the superintendent has said, perhaps he ought to be transferred to another facility --

A Uh-huh.

Q -- is that something that typically you would have discussed with the superintendent?

A Not necessarily. They're in change. If they don't want somebody in their facility for whatever reason, they get rid of them.

Q Including if the reason happens to be medical?

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A Possibly. He might have called me on this one. I don't remember specifically on this. If he called, he would ask something like, do I think he needs to be under 24-hour nursing care, and those sort of things. But ultimately, he's in charge and he makes the decisions. I can only make recommendations to the department.

Q So ultimately, then, it would have been Mr. Hyden's call?

A Oh, yeah.

Q He had the authority to make that transfer?

A If he decided, yes; it's his institution. He has the authority to override my recommendations. If I had said, you know, he has to stay here for a specific reason; it's his institution.

Q Or if you had said, he hasn't come to me with a complaint, I don't know what the problem is here, I don't know why we need to transfer him --

A That's a possibility.

Q Mr. Hyden could have said, well, you're talking about a 70-year-old guy with a defibrillator, let's get him to another facility. He had that authority?

A Oh, absolutely. I'd ask him why; what he felt about that would be indicative of why he had to leave. If he's uncomfortable with anybody, he can get rid of them for any reason.

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Q Did he need approval from anybody in the medical department to do that, as far as you were concerned?

A As far as I'm concerned, no. Again, my experience -- I've had many superintendents I've worked with over the years. Don't make me count how many I've had. They typically would ask, you know, do you think medically that they're unstable; is this somebody that's going to die, going to have a serious medical problem tonight.

Q Would that conversation typically appear anywhere in the record?

A I don't -- I can't think. I don't know.

Q Is there any documentation that we could look to to see whether that occurred?

A A telephone call to me or to central office? I doubt it.

Q It's not the type of thing that you would have made a note in the chart about?

A Depending on how much I thought -- I mean, if the superintendent just asked me a question that I think is just, you know, off the cuff, then probably I wouldn't. If I thought it was something that was significant, it probably would have been.

Q What's the Monday morning meeting?

A Monday morning meetings are managers meeting

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with the superintendent, where all the managers of the different departments get together and discuss what's going on in the facility. Everything from a maintenance issue to problems that we're having.

Q Including medical issues?

A In a general sense. It's not we sit down and we discuss X inmate with X problem. That's almost never done. Typically would be somebody is handicapped and needs special attention; they're wheelchair bound or they need somebody to help them with their dinner trays or what have you medically. I try to give a heads up; this person needs to be on one floor. And staffing issues. You know, if somebody is out sick, anybody that's in the hospital, any ambulance runs we have, those sort of things.

Q Would you typically attend that Monday morning meeting?

A I try to attend every one I can.

Q If you're there on --

A If I'm there and there's not something pressing in the medical department.

Q Are those meetings recorded?

A Tape recorded tape recorded? I've never seen that.

Q Is there somebody who is tasked with writing down what occurs at those meetings?

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A I believe so, but I'm not involved in that.

Q Do you ever get copies of minutes or anything like that?

A No, never. In 21 years, never seen minutes from it.

Q Is this memo talking about Mr. Davis's defibrillator the type of thing that might come up at a Monday morning meeting?

A It might. I would assume, in that situation, Sergeant Barnhart would have been the one that would have brought that up. But chances are that would just stick in the shift office on the side that he was at. And I believe it's a clipboard that they have, special needs type of thing, and they would pass it on to the next shift that comes on.

Q From a security standpoint?

A Security. Because they're the ones that do the wanding. No one else would do it, but the shift supervisor or his or her designee.

Q After your investigation of Mr. Davis's grievance, he filed an appeal, right?

A Right.

Q Were you involved at all in that appeals process?

A No.

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Q Were you made aware of the appeal?
A At one point I was. I think it was long after it had happened. I assumed he was going to appeal from the get-go, though.
Q Why is that?
A Because I wasn't addressing what it was that he wanted addressed.
Q Did you tell him, during the course of your meeting, he was wasting his time?
A I don't know if I told him he was wasting his time. Because what they need to do, which is what he did, is write a grievance. I can't deal with it at my level; then he appeals it up. And my assumption is, as I had told him, you're going to have to appeal this, because I can't address what it is you're asking.
That's why I spent the time on what it is that I could help him with physically in that facility that he was having difficulty with. If you feel you need a blood test, if you feel you need to be put up on the telephone -- some of the defibrillators have a telephone that attaches to it -- if you feel you need this, you need that, you have to put it in a COP-OUT so it gets to me. I'm in four different facilities, and the word doesn't always get back to me if you just verbalize to somebody. To me, in managing the facility, that was how to best

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provide care for this inmate.
So, yes, I would expect him to appeal because that's not what he was grieving. That was the issue that I could assist with, but he was grieving that he wanted 24-hour nursing care. And he did not come from a 24-hour nursing care prior to jail and he wasn't put in that in jail.
Q Did he tell you, in the course of that meeting, that he thought the care he was receiving at Palmer was inadequate?
A I don't remember. That was so long ago. What I remember was that he felt he didn't know how to ask for care. Whether that's what he was meaning or not, that's what I took out of that.
Q Your conclusion was that he didn't know how to access the system?
A Correct. And it's a typical problem. I see that routinely with inmates. It's not a unique situation. I don't understand how it can happen, because they're told repeatedly, and it's in writing and in the handbook. But I see that on many of them.
So I re-explain and try and do it in a way that they understand and try to get affirmation from them that they understand.
Q Do you know whether or not Mr. Davis has any

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difficulty with reading?
A No, I have no idea. If he would have mentioned something along those lines, difficulty with reading and writing, I would always refer them to the inmate legal law library, where they have a guy in there that will write specific write-ups for them. Sometimes they type it; sometime they write it. And any time I know that somebody has a reading/writing disability, that's what I recommend.
Q That they go talk to somebody in the law library?
A Correct. I have no idea if I said that to him or if he even mentioned that. That's too long ago to remember. But that's routinely what I would do.
Q So you expected that Mr. Davis was going to appeal?
A I would have, yes.
Q And he did. Do you remember having any involvement whatsoever in the appeal process?
A No.
Q Were you consulted at all about the appeal?
A No, because again, it was out of my realm. There wouldn't have been any reason for them to contact me.
Q Take a look at the last page of Exhibit 10. That's the response to the appeal.

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A Uh-huh.
Q Have you seen that before?
A Recently I got a copy of that, yes.
Q Do you remember receiving this at all at the time?
A No. Typically, if I would have received that, my initials would be on it.
Q Are you called upon, in your position as health care admini- -- strike that -- as the institutional health care officer, to assist in the appeal process in any way?
A Not very often. They want an independent investigation. They might call and ask my thought on a particular issue. This instance was not anything I could address. If they had questions on his access to medical via the COP-OUT system, that would be a reason to call me. But if he wants to be in a 24-hour nursing facility or make PCC a 24-hour nursing facility, there's nothing that I could think that they could glean from me.
Q Second sentence of the letter from Mel Henry says, "Your grievance is for the facility where you are housed not having adequate medical staff to meet your medical needs," correct?
A Right.
Q Do you know whether or not there was any review done, as part of Mr. Davis's appeal, as to whether his

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medical needs were being adequately met at Palmer?
A I assume there was, but they didn't go through me again. Not that I remember.
Q If you would have been involved in providing information to respond to this appeal, would there be documentation of that somewhere?
A I would think they would do it in the grievance process, the appeal process, that would have been documented.
Q Okay.
A That's how I would do it if I was doing that.
Q Exhibit 9 is a series of documents that also apparently relate to the grievance appeal. Are you familiar with any of those documents?
A Other than what I was given here.
Q Let me ask you this: The first page of that exhibit just appears to be a transmittal to Mel Henry, the health care administrator, from Mike McGinty in Palmer, right?
A Correct.
Q And Sergeant McGinty was the grievance coordinator for Palmer?
A Now it's -- the title has changed now, but yes. The made it a much more complicated title:. Institution facility operations something or other. Yeah, grievance

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coordinator is much easier.
Q Okay.
A How the process goes is the inmate writes a grievance. It would go to Sergeant McGinty. Sergeant McGinty would review the grievance to see if it was for medical or security or parole or whatever else. And if it was an appropriate type of write-up, would refer that to that department, in this case Mr. Davis's grievance to me as institutional health care officer. I investigate that grievance and put my response on there.
It goes back to Sergeant McGinty, who then contacts the superintendent, and they go through that grievance process there, and they respond in writing to the inmate, what the finding is. And the inmate gets a copy of what I put down and what the superintendent put down.
Q Okay.
A Then, if the inmate is unhappy, dissatisfied with those responses, then they can appeal. The appeal generally goes straight to central office for a higher authority to look at the original grievance.
Does that make sense?
Q Yup.
A They do their investigation and contact whoever they need to contact, possibly even the inmate depending

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on the scenario, and they have their conclusions.
And so this was the process of the appeal going to central office.
Q So as far as you remember, at least at this point, once you were done with your investigation and it went to Superintendent Hyden, you're done?
A Correct.
Q And you were not called upon to provide further information by central office as part of the appeal?
A Typically, no. Typically, no. It's so long ago on this one, I don't remember anything else. But typically, I'm not contacted any further. If I had made a blanket statement about what it was that he was grieving for, then yeah, they'd do that. But I can't do this at my level.
Q You may not know the answer to this, but I'll ask it anyway because you're here. This packet that I have given you, the pages 496 through 500, appears to be a packet that went to central office from PCC relating to this grievance.
A I guess. I have no idea what Sergeant McGinty would have sent or not.
Q Okay.
A It's unlikely that Sergeant McGinty -- I wouldn't believe Sergeant McGinty had progress notes.

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Q That was my question --
A I would guess the investigating officer contacted one of my nurses and said, would you photocopy progress notes and fax them to me. That would be my guess. And there's fax transmittals on the progress notes, so yeah, that's how that happened.
Q There is a fax transmittal, but it --
A Right here. That indicates it was faxed.
Q 7/23/1995 looks to be a bit off.
A Well, the fax machine, the power glitches. We're on generator power about a third of the time up there, and it writes out the date and time and it resets to the original. The nurses -- no one can keep up with resetting the date and time on that.
Q Okay. So your expectation is that this was simply faxed into central office?
A That would be my -- yeah.
Q Is that typically what would happen on an appeal like this?
A Oh, yeah, as part of the investigation. The investigating officer would say, do you have progress notes during a time frame, or whatever else. And then, depending who was on, would depend on how much they were faxed.
Q And that's part of what I was trying to figure

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out here.
A And there are other instances where the whole medical file might be shipped off to Anchorage for their investigation.
Q Okay.
A And that makes it hard on me as a practitioner, when your file is gone for, you know, a month.
Q Based on what you see here, it appears that it was these two pages of the progress notes that were faxed?
A Right. And I have no idea if there was more. But that's all that's in my package and I didn't put it together.
Q Well, the last progress note that's in here is 8/26/02. So from that, we can fairly conclude that this was faxed at least as of 8/26/02, right?
A Correct.
Q The page that has the number 502 on the bottom, right after that --
A Uh-huh.
Q -- is that something you're familiar with at all?
A No, other than I just saw it here today. I'm assuming that's part of Sergeant McGinty's log.
Q Know anybody by the name of Paul that would be involved in grievance research?

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A My guess is that that would be Bonnie Paul, who is now a different last name, but she was working for the department in those days as, I believe, the health care operations officer. I think that was her title. She's a nurse practitioner that typically would have been assigned it. Mel Henry was -- the administrator in those days was a Ph.D., not a medical doctor. And so anything to do with medical issues would go to -- most likely to Bonnie Paul first to investigate any grievance appeals.
Q Do you know anything about the last page of this exhibit?
A Never seen it before today. I'm guessing that, again, that's central office grievance log because it has every -- all the different facilities, whether it's an appeal or institutional level.
Q One of the things that I was curious about; maybe you can help me with this. Under the column that says Researcher --
A Uh-huh.
Q -- there are a number of different things that are listed in here. Next to Charlie Davis it says, "Paul," just like the previous page did, which you think means Bonnie Paul, right?
A Yeah. Part of the names are blocked out on mine.

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Q Right.
A Oh, there at the bottom I see, yeah, he does have that.
Q And if you go over to the column that says Researcher, at the top, it says, "Paul," there?
A Again Bonnie.
Q Okay.
A That would be my assumption.
Q Do you know, Mr. Hale, why there are other types of researchers listed here for grievances? For instance, the MAC committee, Paul, Luben, Smithson, those types of things?
A During this time frame, I believe more than one person that would sit in that chair to be the person who went in there. If the department decided that Bonnie Paul was needed, like, in Nome for a week, somebody else would be called in and would sit in and might be -- investigate grievances. And I'm guessing there are certain grievance appeals that the person investigating thought needed a higher authority than them, so they'd take it to the medical advisory committee.
The medical advisory committee in those days, I believe, had Henry Lewgan (ph) -- I mean Henry -- Mel Henry, I'm sorry -- Mel Henry and the pharmacist and Bonnie Paul. They might ask one of us in the field to

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come in and sit on that. A psychiatrist was in there. I think we had a state dentist who would sit in there. And they would round table discuss certain items.
Q And you have participated in that medical advisory --
A Over the years, I have.
Q From time to time?
A Uh-huh.
Q Would you typically participate in that committee if the appeal was from your facility?
A Only if they requested I come in.
Q Just so we're clear, MAC committee, you interpret that to mean --
A Medical advisory.
Q Do you know what ACO staff refers to?
A ACO staff. I don't. I'm sorry. ACO staff, no. Anchorage Central Office is the only thing I could think of. Normally "ACO" means Anchorage Central Office.
Q I take it you don't have any specific memory of participating in a medical advisory committee review of Charlie Davis's appeal?
A No.
(Exhibit 11 marked.)
BY MR. MATTHEWS:
Q Do you recognize this document?

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A I've never seen it before, that I know of.
Q Does it appear to be a COP-OUT form that Charlie Davis filled out --
A Correct.
Q -- complaining about the medical care that he'd received in Palmer?
A Correct.
Q This was about the same time he filed his grievance, wasn't it?
A Yeah. Typically, the grievance officer will not accept a grievance until they've tried to handle it informally. And my guess would be Mr. Davis -- this was his informal attempt to address the issue.
Q There's a note under Final Action Taken, "Noted, BP, 6/12/02." Do you see that?
A Yes.
Q How do you interpret that note?
A Bonnie Paul. That would be my guess.
Q Do you recognize that to be Bonnie Paul's handwriting?
A Not off the top. But I've no reason to think it was anybody else.
Q Were you aware of this COP-OUT at the time you interviewed Mr. Davis as part of your investigation?
A I may have been. I don't remember.

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Q Did your office in Palmer have an EKG machine?
A Yes.
Q Is that something that you ever used for Mr. Davis?
A I don't remember.
Q Would that be recorded in his chart if it was?
A Should have been.
Q Did you have an EKG available in 2002?
A Yes.
Q After Mr. Davis's grievance was filed in June of 2002, and this COP-OUT in earlier June, are you aware of any medical exam that he was ever given at Palmer, by either a nurse, a PA, or a physician?
A Nothing off the top, but he was given the notification by me on how to ask for anything he felt he needed from that point. It's their responsibility to contact us, the formal process, the COP-OUT if he felt he needed something, wanted something, he had a complaint, yeah. Playing ping-pong, hurt his wrist, whatever, he has to ask for that.
Q Is it fair to say that, from your standpoint then, unless he asked you for some further specific care, there was nothing further he needed?
A From my discussion with him. You know, I explained to him that, if you think you need to have a lab

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test, you think you need to have -- whatever it is, you need to put that in writing. Going up to somebody out in the dining hall and complaining about something doesn't get back to me. The only way I can help him if is he contacts me directly and his access to contact me directly is the COP-OUT form. And if he had any pain, discomfort, medication problems, anything at all, he has to contact me. This is how you do it (indicating). That's why I spent 20 minutes discussing that issue, the issue that I could help him with.
Q Which is how to fill out the paperwork?
A How to contact us, how to let us know. I mean, because -- you know, he's typical. He went three places, Lemon Creek, Palmer, Lemon Creek, in a six-month period of time. He has to be the one responsible for his care, in letting us know what it is that he needs.
Q Do you remember having any specific discussions with Mr. Hyden about Charlie Davis?
A No, I don't remember.
Q Did you ever talk to Mr. Henry about Charlie Davis?
A Not that I remember.
Q How about Dr. Luben?
A He wasn't on. Never talked to him about it.
Q Ever talk to Dr. Billman about Charlie Davis?

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A That I may have.
Q But not that appears in your notes anywhere?
A I didn't make any notes on that.
Q Any memory of ever talking to Dr. Kiester about Charlie Davis?
A Not specifically. I'd have to go back through the old logs to see who was in, if it was written down. The dates -- it's around the time where the physicians were starting to change.
Q In the logs that we've looked at this morning, there's no indication that Dr. Kiester was ever involved in Charlie Davis's treatment, is there?
A None.
Q Same thing with Dr. Christensen?
A Correct.
Q No indication whatsoever, right?
A None.
Q Mr. Davis ever complain to you that he was not getting his medication?
A Not to me, that I remember. I believe that's one of the -- you know, that would have been an issue that I would have discussed on how to access and let me know: If you're not getting something you need, you've got to put it down in writing so I know.
Q Did Mr. Davis ever tell you that the COs were

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cutting the med lines?
A I don't understand.
Q Were cutting off the medication line before everybody got their medication.
A I've not heard that before, that I can remember. That would be something that I would be talking to the superintendent about, if I -- even the allegation of that.
Q Mr. Davis raise that at all during his meeting with you?
A Not that I remember. In that line of thought, there's a set time frame for med passing. And they pass the meds in that time frame, and then they close up shop, and the last guy in line is the last guy in line. If somebody comes up 10 minutes after the line is gone and the med cart has gone to another part of the institution, they might miss that way.
Q Okay.
A If that's answering your question.
Q Well, I think so, but let me give you a different example.
A Okay.
Q If the med -- if there's a set time frame for passing out meds --
A Right.
Q -- and it's to run from eight to nine P.M., and

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nine P.M. rolls along and there's still ten people in line, have you ever heard of an instance where the COs have said, you 10 are going to have to wait?
A Not that's been brought to my attention. I wouldn't stand for that.
Q Is that the type of thing you would expect somebody to put in writing if they had a complaint about it?
A Oh, I would expect a grievance, most likely. At minimum, a COP-OUT, but I would expect somebody to complain in a formal manner on that. To me, if I was an inmate and that happened to me, I'd be very concerned.
(Exhibit 12 marked.)
BY MR. MATTHEWS:
Q We're getting to the end here.
This may just be a formality, Mr. Hale, but let me ask you whether you've seen Exhibit 12.
A No.
Q Well, let me ask it this way: Did you bring any documents with you today in order to respond to a request for documents?
A No.
Q Were you asked to provide any documentation for purposes of this deposition?
A No.

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Q Have you been asked to search the records of the medical staff in Palmer for -- in response to this case?
MS. KAMM: Could I say something too, Tom?
MR. MATTHEWS: Sure.
MS. KAMM: We brought that little packet to give to you today. In fact, what you took and renumbered as No. 9 -- as your Exhibit No. 9 -- these are copies of all the documents that we have also given to you in response to defendant's response to plaintiff's third set of requests for production to defendants. But if you want to go ahead and ask him questions, go ahead.
MR. MATTHEWS: Well, all I want to -- all I really want to do is to tie up this loose end and make sure there's no other documents out there that anybody's been able to find responsive to our request.
MS. KAMM: He's not the document keeper.
THE WITNESS: Correct.
MR. MATTHEWS: And that's what I --
THE WITNESS: I was asked questions on these and I referred to the people that possibly could answer that.
MR. MATTHEWS: Okay.
THE WITNESS: When an inmate leaves the facility, the only thing that I've ever had are the medical records and that goes to the facility where they were at, and then, when they're discharged, to a

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centralized area. So the majority of that I wouldn't have access to.
BY MR. MATTHEWS:
Q So with an inmate gone from the facility now for four years, those records would not be in Palmer anymore?
A No. They would be archived in Anchorage, as long as he's out of jail.
MS. KAMM: If I might also say, Tom, I don't think you've had time to respond to -- or not respond, but to review our response because we faxed it when you were out of town. The retention period is three years for a lot of DOC records. So that's why there are no Palmer PCC minutes on daily staff meetings.
MR. MATTHEWS: Okay. You're quite right that I have not had a chance to look at these and I appreciate that you did fax them up earlier this week.
BY MR. MATTHEWS:
Q So you're not the records guy and you didn't bring any records in response to a subpoena?
A No.
Q And with that, we have a formal response from you in terms of the records that are available. So that should suffice.
MS. KAMM: Right. You served with me that subpoena, so I brought the records that I had, which are

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the same that we provided you.
MR. MATTHEWS: Okay. So there's nothing else that can be provided at this point in time?
MS. KAMM: No.
BY MR. MATTHEWS:
Q Let me ask you this, Mr. Hale: You referred to a Monday meeting.
A Correct.
Q Is there a daily managers' meeting?
A Not that I'm involved in.
Q I may have misunderstood what Mr. Hyden said, but there's a weekly managers' meeting.
A Correct. And I believe the security officers and parole officers and the unit team members -- I think they meet daily. But it's not something I've ever been involved with.
Q So if there are daily meetings that occur, it may be something that doesn't include medical representatives?
A Or managers. Floor workers, people that are actually physically doing hands-on, day-to-day in population.
Q The times that you have participated in a medical advisory committee, is there a write-up that's typically done?

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A Not that I've done. I mean, I would assume -- well, because I've seen write-ups from those, so somebody has to do something along those lines.
Q Are something like minutes kept of those meetings?
A I would guess, and/or -- you know, like the appeals or -- what I see from the medical advisory committee, when it was fully functioning back in those days, would be a response to -- I've requested something; I want somebody to have a procedure done. And they would either approve it, deny it, or defer it. And I would get something in writing back that I would generally put in their medical records, on the status of a given test, procedure, medication, whatever it is that I'm asking for.
Q If there was --
A Whether they keep a log of everything they discuss or not, I've never seen that.
Q Are those meetings recorded, to your knowledge?
A I don't remember ever seeing a recorder. They must have some way of doing it; I just -- I never paid attention.
Q There has to be a way of documenting what occurs?
A Yeah, I would think so.
Q Do you remember having any contact with

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Mr. Davis after that grievance meeting on June 27th?
A No, I can't remember any.
Q In your orders in the medical chart, you ordered that Mr. Davis have a PT/INR test done every 30 days, correct?
A I have those written orders, yes.
Q If that test wasn't done for more than 30 days, that would have been contrary to your order?
A Correct.
Q What's the ramification of that?
A Well, if it's a long term, you know, you don't have any idea of what their clotting factor is. Potentially, they could get too high or too low.
Q Was one of Mr. Davis's complaints, when you met with him for his grievance, that he had not been given a timely PT and INR test?
A I don't remember him specifically saying that. He may have, but I don't remember that.
Q Did you have a process of going through medical charts on a regular basis to make sure that your orders were being complied with?
A No.
Q Was there any process for the medical staff to review charts on a regular basis?
A All charts, no. There's random reviews that are

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done.
Q Is it the case that you would not review a medical chart typically unless an inmate came in for a request for medical services?
A That's one of the times. In a situation like him, he's on medication. So at minimum, every 90 days it would be a review of what's gone on in the last 90 days, making sure that, if something was ordered, that it was done.
Q Given the number of medical conditions that Mr. Davis had and the number of medications that he was taking, do you think reviewing his chart every 90 days was appropriate?
A Yes, at a minimum.
Q You don't think it was necessary to do it more than that?
A Again, you have to individualize doing this. We were doing other things, like the flow sheet of blood pressures and the lab tests when they come in; you're reviewing it each time they have that.
Q Would you agree, Mr. Hale, that Mr. Davis, as a prisoner with seven different medications and an implanted defibrillator, was somewhat unique?
A Slightly. I've had people on 23 different medications and multiple prosthetic devices that are much

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more unique.
Q Would it be fair to describe Mr. Davis, from your perspective then, as just another prisoner?
A Well, no, he wasn't typical, but I've seen many similar over the years, or worse. Because of his age of 70 and the other issues, all things that have to be incorporated into it, he was an individual.
Q Did Mr. Davis get any special care because of his medical conditions?
A What do you mean "special care"?
Q Anything out of the ordinary?
A Well, he was getting his blood pressure check, he was getting his blood levels check, medication reviews and that. So, I mean, that's just part of the routine job. I guess I'm not understanding the question.
Q Do you think Mr. Davis needed to be seen on a regular basis?
A He was seen every day by the nursing staff, multiple times a day.
Q When they dispensed medications?
A Correct.
Q But if he made complaints to them about his medical condition in the med line, that wasn't the appropriate place to do it, from your perspective?
A If it was a routine complaint, correct. If he

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had an emergency, they'd deal with it on the spot.
Q If he was complaining of dizziness, nosebleeds, fainting spells, things like that, is that an emergency?
A It depends on what the nurse triage does. That's why we have the nurses. They're taught how to triage those situations. And it may be an emergency; it may not.
Q And if it's not considered an emergency at the time, would he typically be told, put in a COP-OUT, come to clinic?
A Right, fill out a COP-OUT.
Q So if you fill out the paperwork correctly, you will get seen?
A If necessary. You may not be seen if you fill in a COP-OUT. Again, it goes back to the triage. The nurses triage -- are supposed to triage any condition that comes along.
Q Any condition that comes along in a med line or any condition --
A At all.
Q Any --
A Because there was a process for them to access medical. And the -- routinely -- I can't say specifically on Mr. Davis; I wasn't there. But routinely, inmates come up at med lines and they'll have a laundry list of

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problems that they've had for the last six months or year or whatever and want them resolved there. And it's just impossible to do that. And so they ask a series of questions. Dizziness, in and of itself -- you know, it can be something really minor; it could be something significant. I would expect the nurses to try and get a better idea of what's going on: Is this something that's happened in the last five minutes, the last hour, has it been going on for weeks, months, years, that sort of thing. Same with nosebleeds: You got it one time, do you have it now, that sort of thing.
So as a practitioner, I rely on the nurses daily seeing these people: Is the person ashen, gray; do they look on death's door; do they have other complaints, versus somebody that comes up with a laundry list of problems. Most of the time they're pretty good at it.
MR. MATTHEWS: Thank you, Mr. Hale. I appreciate your time.
THE WITNESS: All right.
MR. MATTHEWS: That's all the questions I have.
MS. KAMM: No questions.
(Proceedings adjourned at 1:10 p.m.)

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CERTIFICATE
I hereby certify that I have read the foregoing transcript and accept it as true and correct, with the following exceptions:

PAGE	LINE	CORRECTION

Date: 8/25/06 Roger Hale

(Use additional paper to note corrections as needed, signing and dating each page.) (SW)

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REPORTER'S CERTIFICATE

I, SUSAN J. WARNICK, RPR, and Notary Public in and for the State of Alaska do hereby certify:

That the witness in the foregoing proceedings was duly sworn; that the proceedings were then taken before me at the time and place herein set forth; that the testimony and proceedings were reported stenographically by me and later transcribed under my direction by computer transcription; that the foregoing is a true record of the testimony and proceedings taken at that time; and that I am not a party to nor have I any interest in the outcome of the action herein contained.

IN WITNESS WHEREOF, I have hereunto subscribed my hand and affixed my seal this _____ day of _____, 2006.

_____

SUSAN J. WARNICK,
Registered Professional Reporter
Notary Public for Alaska

My Commission Expires: April 8, 2010